

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/26/2017
FORM APPROVED
OMB NO. 0938-0391

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|---|---|---|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085035 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 01/19/2017 |
| NAME OF PROVIDER OR SUPPLIER DELAWARE HOSPITAL F/T CHRONICALLY ILL (DHC) | | | STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNNYSIDE ROAD SMYRNA, DE 19977 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 000 | <p>INITIAL COMMENTS</p> <p>An unannounced complaint survey was conducted on January 17, 2017 and January 19, 2017. The facility census on the first day of the survey was 136. The resident sample size was 10.</p> <p>No deficiencies were identified at the time of the survey.</p> | F 000 | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

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NAME OF FACILITY: Delaware Hospital for the Chronically III **DATE SURVEY COMPLETED:** January 19, 2017

| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES | COMPLETION DATE |
|---------|--|---|--------------------|
| 3201 | <p>The State Report incorporates by references and also cites the findings specified in the Federal Report.</p> <p>An unannounced complaint survey was conducted at this facility on January 19, 2017.</p> <p>Regulations for Skilled and Intermediate Care Facilities</p> <p>Based on observations, record reviews, staff interviews, and review of other facility documentation there were no deficiencies found.</p> | | |

Provider's Signature


NHA

Title

HOSPITAL
DIRECTOR
DHCF

Date

1-26-17